

## Bill To and Ship To

Bill To (legal name):	Ship To: <input type="checkbox"/> Check Here is Same as Bill To
Street Number:	Street Number:
City:                      State:                      Zip:	City:                      State:                      Zip:
Phone Number: (    )	Phone Number: (    )
Fax Number: (    )	Fax Number: (    )
Accounts Payable Contact:	Purchasing Contact:
Email Address:	

## Company Information

Payer Mix: (Please enter the percentage of each.) ___ Medicare    ___ Medicaid    ___ Self-Pay    ___ Other	Type of Organization: <input type="checkbox"/> Corporation (type)    ___ <input type="checkbox"/> Proprietorship <input type="checkbox"/> Partnership (type)    ___
Exempt from Sales/Use Tax: Yes <input type="checkbox"/> No <input type="checkbox"/> (Please attached a copy of your Sellers Permit and Resale Certificate)	Est. Avg. CuraScript Purchases per Month:
Name on State License:	Name on DEA License:
State License Number: (Please attach a copy)	DEA License No: (Please attach a copy)
Expiration Date:	Expiration Date:
Federal Tax ID Number/SS#:	Years in business:

\*Upon review of your application, you may be required to supply copies of your balance sheet, income statement and statement of cash flows.

## Vendor References

Primary Drug Wholesaler:	Acct Number:	Phone Number: (    ) Contact:
Other Supplier:	Acct Number:	Phone Number: (    ) Contact:

## Bank References

Name:	Branch/Address:	Checking Acct. Number:
Contact:		Loan Acct. Number:
Phone Number: (    )		Line of Credit Acct Number:
Any involuntary liens or prior bankruptcies? Yes <input type="checkbox"/> No <input type="checkbox"/> (if yes, please provide the date, court & case #)		
*By completing the Credit Application and signing the accompanying Terms and Conditions, you are authorizing CuraScript SD to conduct a bank reference check.		

Please fax with provided  
cover sheet or mail to:

Customer Service c/o CuraScript SD Specialty Distribution  
255 Technology Park Lake Mary, FL 32746

# TERMS AND CONDITIONS



This application is submitted to Priority Healthcare Distribution Inc. doing business as CuraScript SD Specialty Distribution (hereinafter referred to as CSD) for the purpose of obtaining commercial credit. The undersigned represents and warrants that all information herein is current, correct and complete, and that CSD may rely on such information in deciding to extend or discontinue credit. The undersigned agrees to notify CSD immediately in writing of any change in the foregoing information including, without limitation, any change in the nature of business, ownership, name or location of the business or financial condition of the undersigned. The undersigned agrees to furnish current financial information from time to time as requested by CSD.

The undersigned acknowledges that before any credit purchases can be made, CSD must first approve this application and alternative forms of security may also be required. CSD may limit or discontinue any credit at its sole discretion. The undersigned authorizes CSD and any credit agency or investigatory service engaged by CSD to verify or otherwise investigate any information contained herein, or reference listed, statements, reports or other information obtained with respect to the undersigned from any other source, as CSD deems appropriate. The undersigned agrees to release all persons, companies or corporations using or supplying such information, including CSD, from any claims and/or losses that may result therefrom.

The prices for items purchased by the undersigned from CSD may include discounts or other reductions in price, and/or may be subject to subsequent rebates or other reductions or adjustments. By signing this credit application, the undersigned acknowledges that it must, to the extent required, report or reflect such discounts or reductions on cost reports or claims filed with federal or state health care programs, and the undersigned acknowledges that it should retain all CSD invoices and other documentation of discounts and make such information available to federal or state health care program officials upon request.

The undersigned understands and agrees that participating vendors (e.g., pharmaceutical manufacturers) from which CSD purchases goods may pay an administrative fee to CSD of 3 percent or less of the purchase price of the goods provided by that vendor. The administrative fee pays for services performed by CSD, such as the administration of chargebacks. If the undersigned is a health care "provider of services," which generally means a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice program (see 42 U.S.C. § 1320a-7b(b)(3)(C)(ii) (citing the definition of "provider of services" at 42 U.S.C. § 1395x(u))), then the undersigned shall designate itself as such in writing to CSD, and CSD shall provide the undersigned with information, at least annually, and to the Secretary of the U.S. Department of Health and Human Services upon request, the amount received from each vendor with respect to purchases made by or on behalf of the undersigned. If you need additional information regarding administrative fees in order to comply with any legal reporting obligations you have, please contact CSD.

The undersigned agrees to pay in a timely manner all debts, accounts and invoices owing to CSD in full accordance with the agreed upon terms of sale as printed on invoices and that the due date for each invoice is the date by which payment must be received at the CSD "remit to" address noted on invoices and statements. The undersigned acknowledges that all statements of account shall be considered true and correct, unless the undersigned contests the accuracy of any such statement within 30 days of the date thereof, by sending a written inquiry to CSD. The undersigned agrees that in the event such debts, accounts or invoices are not paid when due, they will accrue late charges at the rate of eighteen percent (18%) per annum or the maximum rate allowed by law, whichever is the lesser rate. CSD reserves the right to apply any and all past-due moneys however it deems appropriate.

The undersigned agrees that: (1) this agreement shall be deemed fully executed and preformed in the State of Florida and shall be governed by and construed in accordance with the laws thereof; (2) in any action, proceeding, or appeal of any matter relating to or arising out of this judgment, the undersigned shall be subject to jurisdiction of the State of Florida and accept venue in Seminole County, Florida; and (3) the undersigned expressly waives any right to a trial by jury. The undersigned agrees to reimburse CSD for any attorney fees, court costs or collection agency fees CSD may incur in its efforts to collect any past-due amounts.

Upon submission of this application to CSD and review by CSD of the same, the undersigned acknowledges that, prior to the extension of credit by CSD to the undersigned, CSD may require that the undersigned obtain a standby letter of credit in favor of CSD and/or a personal guaranty of one or more principals of the undersigned in favor of CSD (examples of each may be provided upon request). In addition to, undersigned may also be required to provide proof of legal entity.

Please complete the name of the entity on behalf of which this credit application is being submitted, print your full name, title/position, date and sign in your official capacity on behalf of the entity.

**By signing below, you certify that you have read and agree to the Terms and Conditions contained in this application.**

Entity: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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255 Technology Park Lake Mary, FL 32746